		FOR OHF USE					

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0039826

Facility Name: Mount Vernon Care Center

Address: 1717 Jefferson Street (Number) Mount Vernon (City) 62864 (Zip Code)

County: Jefferson

Telephone Number: (618) 244-2861 **Fax #** (618) 244-7677

IDPA ID Number: 391516877002

Date of Initial License for Current Owners: 10/01/94

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(c)(3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/02 to 06/30/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/02 Ending: 06/30/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	64	Intermediate (ICF)	64	23,360	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	64	TOTALS	64	23,360	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	16,347	3,815		20,162	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,347	3,815		20,162	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 86.31%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/1/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/1/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified 0 and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/03 Fiscal Year: 06/30/03

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/02 Ending: 06/30/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	78,997	8,529	4,259	91,785		91,785		91,785			1
2	Food Purchase		76,411		76,411		76,411	(10,125)	66,286			2
3	Housekeeping	51,893	5,987		57,880		57,880		57,880			3
4	Laundry	30,147	7,301		37,448		37,448		37,448			4
5	Heat and Other Utilities			37,889	37,889		37,889		37,889			5
6	Maintenance	10,531		18,024	28,555		28,555		28,555			6
7	Other (specify):*											7
8	**TOTAL General Services**	171,568	98,228	60,172	329,968		329,968	(10,125)	319,843			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	539,853	21,809	622	562,284		562,284	30	562,314			10
10a	Therapy			112	112		112		112			10a
11	Activities	15,869	1,972	1,207	19,048		19,048		19,048			11
12	Social Services	17,048		698	17,746		17,746		17,746			12
13	Nurse Aide Training	6,997		1,448	8,445		8,445		8,445			13
14	Program Transportation			264	264		264		264			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	579,767	23,781	10,351	613,899		613,899	30	613,929			16
	C. General Administration											
17	Administrative	44,019		99,000	143,019		143,019		143,019			17
18	Directors Fees											18
19	Professional Services			720	720		720	18,507	19,227			19
20	Dues, Fees, Subscriptions & Promotions			2,555	2,555		2,555	38	2,593			20
21	Clerical & General Office Expenses	19,055	3,198	13,854	36,107		36,107	2,283	38,390			21
22	Employee Benefits & Payroll Taxes			98,384	98,384		98,384	40,610	138,994			22
23	Inservice Training & Education			50	50		50		50			23
24	Travel and Seminar			779	779		779	254	1,033			24
25	Other Admin. Staff Transportation			95	95		95		95			25
26	Insurance-Prop.Liab.Malpractice			(63)	(63)		(63)	37,259	37,196			26
27	Other (specify):*											27
28	**TOTAL General Administration**	63,074	3,198	215,374	281,646		281,646	98,951	380,597			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	814,409	125,207	285,897	1,225,513		1,225,513	88,856	1,314,369			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

** See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Mount Vernon Care Center #0039826 Report Period Beginning: 07/01/02 Ending: 06/30/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	D. Ownership											
30	Depreciation			6,275	6,275		6,275	62,795	69,070			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			1,523	1,523		1,523	171,122	172,645			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds			256,545	256,545		256,545	(256,545)				34
35	Rent-Equipment & Vehicles			344	344		344		344			35
36	Other (specify):* MIP							2,439	2,439			36
37	**TOTAL Ownership**			264,687	264,687		264,687	(20,189)	244,498			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			35,040	35,040		35,040		35,040			42
43	Other (specify):* Nonallowable Costs			7,687	7,687		7,687	(7,687)				43
44	**TOTAL Special Cost Centers**			42,727	42,727		42,727	(7,687)	35,040			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	814,409	125,207	593,311	1,532,927		1,532,927	60,980	1,593,907			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/02 Ending: 06/30/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(348)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	3,468	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(1,966)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(14,423)	43		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(195)	43		24
25	Fund Raising, Advertising and Promotional	(478)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(1,128)	43		28
29	Other-Attach Schedule Miscellaneous Income Offset	(65)	21		29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (15,135)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	76,115		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$ 76,115		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ 60,980		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Mount Vernon Care Center

ID# 0039826

Report Period Beginning: 07/01/02

Ending: 06/30/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Mount Vernon Care Center **#** 0039826 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	30	0	0	0	0	0	0	0	0	0	30	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	30	0	0	0	0	0	0	0	0	0	30	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	12,407	6,100	0	0	0	0	0	0	0	0	18,507	19
20	Fees, Subscriptions & Promotions	0	5	33	0	0	0	0	0	0	0	0	38	20
21	Clerical & General Office Expenses	0	2,348	0	0	0	0	0	0	0	0	0	2,348	21
22	Employee Benefits & Payroll Taxes	0	30,485	0	0	0	0	0	0	0	0	0	30,485	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	254	0	0	0	0	0	0	0	0	0	254	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	22,631	14,628	0	0	0	0	0	0	0	0	37,259	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	68,130	20,761	0	0	0	0	0	0	0	0	88,891	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	0	68,160	20,761	0	0	0	0	0	0	0	0	88,921	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Mount Vernon Care Center # 0039826 **Report Period Beginning:** 07/01/02 **Ending:** 06/30/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	3,468	0	59,327	0	0	0	0	0	0	0	0	62,795	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,966)	62	173,026	0	0	0	0	0	0	0	0	171,122	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	(256,545)	0	0	0	0	0	0	0	0	(256,545)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	2,439	0	0	0	0	0	0	0	0	2,439	36
37	**TOTAL Ownership**	1,502	62	(21,753)	0	0	0	0	0	0	0	0	(20,189)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(16,572)	0	8,885	0	0	0	0	0	0	0	0	(7,687)	43
44	**TOTAL Special Cost Centers**	(16,572)	0	8,885	0	0	0	0	0	0	0	0	(7,687)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(15,070)	68,222	7,893	0	0	0	0	0	0	0	0	61,045	45

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Caravilla Resident Centers, Inc.	100.00%	Jeffersonian Care Center	Mt. Vernon	Caravilla Charitable		
		Casey Care Center	Mt. Vernon	Corporation	Mt. Vernon	Lessor
Note: No board member provided services to the nursing home during the reporting period. No business entity owned by a board member conducted business transactions						
with the nursing home during the reporting period.						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	10	Nursing supplies	$	Caravilla Resident Centers, Inc.	100.00%	$ 30	$ 30	1
2	V	19	Professional fees		Caravilla Resident Centers, Inc.	100.00%	12,407	12,407	2
3	V	20	Licenses, dues & subscriptions		Caravilla Resident Centers, Inc.	100.00%	5	5	3
4	V	21	Office supplies & telephone		Caravilla Resident Centers, Inc.	100.00%	2,348	2,348	4
5	V	22	Emp. Benefits & payroll taxes		Caravilla Resident Centers, Inc.	100.00%	30,485	30,485	5
6	V	24	Travel & seminar		Caravilla Resident Centers, Inc.	100.00%	254	254	6
7	V	26	Vehicle, fire & liab. insurance		Caravilla Resident Centers, Inc.	100.00%	22,631	22,631	7
8	V	32	Interest expense		Caravilla Resident Centers, Inc.	100.00%	62	62	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 68,222	$ * 68,222	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	19	Professional fees	$	Caravilla Charitable Corporation	**	$ 6,100	$ 6,100	15
16	V	20	Licenses, dues & subscriptions		Caravilla Charitable Corporation	**	33	33	16
17	V	26	Vehicle, fire & liab. insurance		Caravilla Charitable Corporation	**	14,628	14,628	17
18	V	30	Depreciation		Caravilla Charitable Corporation	**	59,327	59,327	18
19	V	32	Interest expense		Caravilla Charitable Corporation	**	173,026	173,026	19
20	V	34	Rent expense	256,545	Caravilla Charitable Corporation	**		(256,545)	20
21	V	36	MIP - Insurance		Caravilla Charitable Corporation	**	2,439	2,439	21
22	V	43	Penalties		Caravilla Charitable Corporation	**	8,885	8,885	22
23	V								23
24	V								24
25	V								25
26	V								26
27	V				**Caravilla Charitable Corporation and Caravilla				27
28	V				Resident Centers, Inc. have the same board of directors.				28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 256,545			$ 264,438	$ * 7,893	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/02 Ending: 06/30/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Robert Bauer	President	Board Member	None	None	2 hrs/mtg.		None	$ 0		1
2	Roger Ryan	Vice President	Board Member	None	None	2 hrs/mtg.		None	0		2
3	William Armstrong	Treasurer	Board Member	None	None	2 hrs/mtg.		None	0		3
4	Kay Baker	Secretary	Board Member	None	None	2 hrs/mtg.		None	0		4
5	Ronald O'Daniell	Director	Board Member	None	None	2 hrs/mtg.		None	0		5
6	Merla McCloud	Recorder	Administrative	None	None	2 hrs/mtg.		None	0		6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/02 Ending: 06/30/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Caravilla Resident Centers, Inc.
Street Address: 2020 W. War Memorial Dr., Suite 302
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 685-0595
Fax Number: (309) 685-9596

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	Nursing supplies	Number of beds	235	3	$ 110	$	64	$ 30	1
2	19	Professional fees	Number of beds	235	3	45,556		64	12,407	2
3	20	Licenses, dues & subscriptions	Number of beds	235	3	19		64	5	3
4	21	Office supplies & telephone	Number of beds	235	3	8,520		64	2,348	4
5	24	Travel & seminar	Number of beds	235	3	1,036		64	254	5
6	32	Interest expense	Number of beds	235	3	312		64	62	6
7										7
8										8
9										9
10	22	Emp. benefits & payroll taxes	Direct method						30,485	10
11	26	Vehicle, fire & liab. insurance	Direct method						22,631	11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 55,553	$		$ 68,222	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/02 Ending: 06/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	Continental Wingate		x	Purchase facility	$55,560.00	09/01/96	$ 7,402,500	$ 1,954,072	10/01/31	0.0855	$ 166,977	1
2	NCS Healthcare, Inc.		x	Hardware/Software	$689.00	10/31/98	27,579	6,220	09/30/03	0.1429		2
3												3
4												4
5							Amortization expense				2,633	5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related				$56,249.00		$ 7,430,079	$ 1,960,292			$ 169,610	9
	B. Non-Facility Related*											
10							Finance charges				1,585	10
11							Offset on interest income				(406)	11
12							Non-allowable finance charges				(1,585)	12
13							Parent company allocation				3,441	13
14	TOTAL Non-Facility Related						$	$			$ 3,035	14
15	TOTALS (line 9+line14)						$ 7,430,079	$ 1,960,292			$ 172,645	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ 2,439 Line # 36

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

SEE ACCOUNTANTS' COMPILATION REPORT

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/02 Ending: 06/30/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$		1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	N/A	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998		8
1999		9
2000		10
2001		11
2002		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, [illegible]

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Mount Vernon Care Center COUNTY Jefferson

FACILITY IDPH LICENSE NUMBER 0039826

CONTACT PERSON REGARDING THIS REPORT Allan Herrmann

TELEPHONE (309) 685-0595 FAX #: (309) 685-9596

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not l entered in Column D. Do not include cost for any period other than calendar year 200

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.	N/A		$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill whic is normally paid during 2003.

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/02 Ending: 06/30/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 13,500 B. General Construction Type: Exterior Brick Frame Block Number of Stories One

C. Does the Operating Entity? [ ] (a) Own the Facility [x] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	81,300	1994	$ 60,000	1
2					2
3	TOTALS	81,300		$ 60,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	64		1994	1994	$ 1,229,600	$	40	$ 30,740	$ 30,740	$ 268,975	4
5			1998	1998	5,394		40	135	135	742	5
6											6
7											7
8											8
	Improvement Type**										
9	Building improvements			1995	3,187		15	212	212	1,763	9
10	Architectural services			1996	4,794		15	320	320	2,040	10
11	Architectural services			1997	1,198		15	80	80	510	11
12	Air compressor			1996	1,230		15	82	82	523	12
13	Electrical			1996	1,710		15	114	114	727	13
14	Exit lighting			1997	1,354		15	90	90	574	14
15	Blinds, wallpaper & paint			1997	3,329		15	222	222	1,411	15
16	Waterproof basement			1997	7,822		15	521	521	3,322	16
17	Windows & doors			1997	2,878		15	192	192	1,224	17
18	Plastering			1997	20,386		15	1,359	1,359	8,664	18
19	Flooring			1997	4,544		15	303	303	1,666	19
20	Gutters			1997	8,933		15	596	596	3,278	20
21	Shutters & windows			1997	1,882		15	125	125	688	21
22	Remodeling of facility			1997	4,153		15	277	277	1,523	22
23	Plumbing			1997	15,420		15	1,028	1,028	5,654	23
24	Electrical service			1997	32,765		15	2,184	2,184	12,012	24
25	Paint & wallpaper			1997	8,366		15	558	558	3,069	25
26	Sidewalk			1997	780		15	52	52	286	26
27	Electrical service			1998	1,340		15	89	89	490	27
28	Flooring			1998	27,771		15	1,851	1,851	10,181	28
29	Remodeling of facility			1998	154		15	10	10	55	29
30	Paint & wallpaper			1998	262		15	17	17	94	30
31	Landscaping			1998	7,964		15	531	531	2,920	31
32	Windows			1998	1,599		15	107	107	588	32
33	Air conditioner			1998	578		15	39	39	215	33
34	Landscaping			1999	1,699		15	113	113	509	34
35	Cabinets			1999	1,220		15	81	81	365	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Renovation of nurse station	1999	$ 6,059	$	15	$ 404	$ 404	$ 1,818	37
38	Security System	1999	1,245		15	83	83	374	38
39	Water heater	1999	1,990	132	15	132		462	39
40	Remodel resident rooms	1999	3,343		15	222	222	777	40
41	Remodel resident rooms	1999	3,477		15	232	232	812	41
42	Remodel common room	1999	942		15	62	62	217	42
43	Remodel common room	1999	3,212		15	214	214	749	43
44	Trim	1999	671		15	44	44	154	44
45	Door	2000	984	66	15	66		231	45
46	Concrete Floor Pad	2000	1,500	100	15	100		250	46
47	Air Compressor	2001	1,803	120	15	120		300	47
48	Labor for building improvements	2000	13,971		15	931	931	2,793	48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,441,509	$ 418		$ 44,638	$ 44,220	$ 343,005	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/02 Ending: 06/30/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 230,196	$ 4,590	$ 23,165	$ 18,575	5-10 years	$ 168,234	71
72	Current Year Purchases	4,784	478	478		5 years	478	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 234,980	$ 5,068	$ 23,643	$ 18,575		$ 168,712	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident Transportation	1997 Ford E150***	1997	$ 13,040	$	$	$	3	$ 13,040	76
77	Resident Transportation	1998 Chevy Corsica***	2002	489	163	163		3	244	77
78	Resident Transportation	1997 Ford Taurus***	2002	978	326	326		3	489	78
79	Resident Transportation	1992 Chevy Van***	2002	900	300	300		3	450	79
80	TOTALS			$ 15,407	$ 789	$ 789	$		$ 14,223	80

*** Cost allocated between 3 facilities

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,751,896	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 6,275	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 69,070	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 62,795	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 525,940	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/02 Ending: 06/30/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. N/A
This amount was calculated by dividing the total amount to be amortized N/A
by the length of the lease N/A .

9. Option to Buy: ☐ YES ☐ NO Terms: N/A *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 344 Description: Water Cooler $77; Copier $267
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	x
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER AIDE	40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	x
IN OTHER FACILITY	
HOURS PER AIDE	80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$ 1,223	$	$ 1,223
2	Books and Supplies		225		225
3	Classroom Wages (a)		6,997		6,997
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 8,445	$	$ 8,445
10	SUM OF line 9, col. 1 and 2 (e)	$ 8,445			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ 4,787

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	5
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	5

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care	N/A	visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/02 Ending: 06/30/03

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/03 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 38,063	$ 38,063	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 7,614)	195,325	195,325	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	12,654	12,654	6
7	Other Prepaid Expenses	4,653	4,653	7
8	Accounts Receivable (owners or related parties)	483,710	483,710	8
9	Other(specify): Deposit	4,136	4,136	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 738,541	$ 738,541	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		60,000	13
14	Buildings, at Historical Cost		1,234,994	14
15	Leasehold Improvements, at Historical Cost	6,276	206,515	15
16	Equipment, at Historical Cost	39,557	250,387	16
17	Accumulated Depreciation (book methods)	(23,246)	(525,940)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Investment in Sub.	1,500	1,500	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 24,087	$ 1,227,456	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 762,628	$ 1,965,997	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 53,867	$ 53,867	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	6,220	6,220	29
30	Accrued Salaries Payable	43,630	43,630	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	612,328	67,170	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 716,045	$ 170,887	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		1,954,072	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 1,954,072	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 716,045	$ 2,124,959	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 46,583	$ (158,962)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 762,628	$ 1,965,997	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Mount Vernon Care Center
Provider # 0039826
June 30, 2003

Schedule 17A

XV. Balance Sheet

	Operating	After Consolidation
Line 36 - Other		
Accrued Expense	5,019	5,019
Accrued Rent	545,158	-
Accrued Participation Fees	17,372	17,372
Accrued Insurance	18,961	18,961
Resident Credit Balances	25,818	25,818
Total	612,328	67,170

See Accountants' Compilation Report

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 41,032	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 41,032	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	73,773	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) **Certain expense allocations**		15
16	Other (describe) **added back in column 7**	(68,222)	16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 5,551	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 46,583	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 1,551,268	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,551,268	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	1,418	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 1,418	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	4,787	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	650	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	4,124	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 9,561	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	381	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 381	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a	See attached Schedule 19a	44,072	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 44,072	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,606,700	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	329,968	31
32	Health Care	613,899	32
33	General Administration	281,646	33
	B. Capital Expense		
34	Ownership	264,687	34
	C. Ancillary Expense		
35	Special Cost Centers	7,687	35
36	Provider Participation Fee	35,040	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,532,927	40
41	**Income before Income Taxes (line 30 minus line 40)****	73,773	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 73,773	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation. A federal tax return is filed for the combined divisions of Caravilla Resident Centers, Inc.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Mount Vernon Care Center
Provider # 0039826
June 30, 2003 **Schedule 19A**

XVII. Income Statement
Line 28: Settlement Income

Description	Amount
Vending Income	1,119
Miscellaneous Income	65
Forgiveness of Debt	42,888
Total	44,072

See Accountants' Compilation Report

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/02 Ending: 06/30/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,929	2,051	$ 34,470	$ 16.81	1
2	Assistant Director of Nursing	708	741	10,554	14.24	2
3	Registered Nurses	1,257	1,339	20,995	15.68	3
4	Licensed Practical Nurses	10,555	11,202	143,459	12.81	4
5	Nurse Aides & Orderlies	35,903	38,418	290,323	7.56	5
6	Nurse Aide Trainees	600	600	6,997	11.66	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,067	2,159	17,745	8.22	8
9	Activity Director					9
10	Activity Assistants	2,447	2,497	15,869	6.36	10
11	Social Service Workers	1,863	2,114	17,048	8.06	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	11,461	12,198	78,997	6.48	15
16	Dishwashers					16
17	Maintenance Workers	1,356	1,374	10,531	7.66	17
18	Housekeepers	7,968	8,291	51,893	6.26	18
19	Laundry	4,218	4,602	30,147	6.55	19
20	Administrator	1,976	2,180	44,019	20.19	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,940	2,060	19,055	9.25	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	571	608	4,173	6.86	31
32	Other Health Ca See Sch 20A	1,363	1,399	18,134	12.96	32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	88,182	93,833	$ 814,409 *	$ 8.68	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	96	$ 4,259	L1, C3	35
36	Medical Director	Monthly	6,000	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant	Monthly	622	L10, C3	38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	4	112	L10a, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	13	698	L11, C3	44
45	Social Service Consultant	13	698	L12, C3	45
46	Other(specify) Office Consultant	Monthly	1,961	L21, C3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	126	$ 14,350		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Mount Vernon Care Center
Provider # 0039826
June 30, 2003

Schedule 20A

XVIII. A. Staffing and Salary Costs
Line 32 - Other Health Care

Title	Hours Worked	Hours Paid	Salaries	Average Hourly Wage
Care Plan Coordinator	1,133	1,151	16,398	14.25
Ancillary Clerk	230	248	1,736	7.00
Total	1,363	1,399	18,134	12.96

See Accountants' Compilation Report

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Carrell Breeze	Administrator	0%	$ 44,019
TOTAL (agree to Schedule V, line 17, col. 1)			$ 44,019
(List each licensed administrator separately.)			

B. Administrative - Other

Description	Amount
Developmental Services of Illinois, Inc. - Administrative Service Fees	$ 99,000
TOTAL (agree to Schedule V, line 17, col. 3)	$ 99,000
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Personnel Planners	U/C Consulting	$ 720
TOTAL (agree to Schedule V, line 19, column 3)		$ 720
(If total legal fees exceed $2500 attach copy of invoices.)		

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 30,486
Unemployment Compensation Insurance	7,119
FICA Taxes	62,581
Employee Health Insurance	25,264
Employee Meals	10,125
Illinois Municipal Retirement Fund (IMRF)*	
Employee Physicals	2,121
Employee Morale	1,298
TOTAL (agree to Schedule V, line 22, col.8)	$ 138,994

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 200
Advertising: Employee Recruitment	1,148
Health Care Worker Background Check	721
(Indicate # of checks performed 103)	
Miscellaneous Dues and Licenses	491
Expense Allocation	33
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 2,593

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	270
Seminar Expense	763
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,033

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Mount Vernon Care Center
Provider #: 0039826
07/01/02 to 06/30/03

Schedule 21A

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)		720
Allocated from Caravilla Charitable Corporation:		
Altschuler, Melvoin & Glasser LLP	Accounting	6,100
Allocated from Caravilla Resident Centers, Inc.:		
Altschuler, Melvoin & Glasser LLP	Accounting	9,352
American Express Tax & Business Services	Accounting	540
Lawrence Manson	Legal	2,515
Total (agree to Schedule V, line 19, column 8)		19,227

See Accountants' Compilation Report

Caravilla Residential Centers, Inc.
Legal Fees Allocation
June 30, 2003

Professional Fees:

Lawrence Manson	9,233
	9,233

Detailed legal invoice listing:

Lawrence Manson	2,120
Lawrence Manson	540
Lawrence Manson	980
Lawrence Manson	2,060
Lawrence Manson	2,740
Lawrence Manson	793
	9,233

	Mt. Vernon	Jeffersonian	Casey Care	Total
number of beds	64	65	106	235
allocation %	0.27	0.28	0.45	1
Lawrence Manson	2,515	2,554	4,165	9,233
	-	-	-	-
	2,515	2,554	4,165	9,233

See Accountants' Compilation Report

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/02 Ending: 06/30/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1			$		$	$	$	$	$	$	$	$	$
2													
3						N/A							
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Mount Vernon Care Center # 0039826 Report Period Beginning: 07/01/02 Ending: 06/30/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount. **N/A**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **No** If YES, have these costs
been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **5 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **318** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? _____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES _____ NO **x** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **35,040**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **10,125** Has any meal income been offset against
related costs? **No** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **74%**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Altschuler, Melvoin and Glasser LLP** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **No** If no, please explain. **Audit is currently in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Mount Vernon Care Cen** **12:43 PM** **11/04/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	60,980	equal to	60,980	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	172,645	equal to	172,645	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	0	equal to	0	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	69,070	equal to	69,070	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	344	equal to	344	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	8,445	equal to	8,445	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	112	equal to	112	0	O.K.	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies		equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	329,968	equal to	329,968	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	613,899	equal to	613,899	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	281,646	equal to	281,646	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	264,687	equal to	264,687	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	7,687	equal to	7,687	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	35,040	equal to	35,040	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	503,974	equal to	539,853	-35,879	FAILED	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	6,997	< or = to	6,997	0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	15,869	equal to	15,869	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	17,048	equal to	17,048	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	78,997	equal to	78,997	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	10,531	equal to	10,531	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	51,893	equal to	51,893	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	30,147	equal to	30,147	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	44,019	equal to	44,019	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	19,055	equal to	19,055	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	814,409	equal to	814,409	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	4,259	< or = to	4,259	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	6,000	< or = to	6,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	622	< or = to	622	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	698	< or = to	1,207	-509	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	698	< or = to	698	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	44,019	equal to	44,019	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	99,000	equal to	99,000	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	720	equal to	720	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	138,994	equal to	138,994	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	2,593	equal to	2,593	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	1,033	equal to	1,033	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	35,040	equal to	35,040	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	10,125	< or = to	40,610	-30,485	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	10,125	equal to	10,125	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	6,997	equal to	6,997	0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	N/A	equal to	0	#VALUE!	#VALUE!	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	76,115	equal to	76,115	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	1,960,292	equal to	1,960,292	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	N/A	equal to		0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	60,000	equal to	60,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,441,509	equal to	1,441,509	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	250,387	equal to	250,387	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	525,940	equal to	525,940	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	46,583	equal to	46,583	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	73,773	equal to	73,773	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	762,628	equal to	762,628	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

Enter Cost Center Expenses

YOU HAVE CHOSEN THE SUPPORT CALC. THAT IS LINK TO THE COST REPORT!! 11/04/05 12:43:00 PM

HSA Number 5 Name **Mount Vernon Care Center**

Cost report period From: 07/01/02 To: 06/30/03 Base Number 330

If this is an ICF/DD 16 facility, enter a 1 in cell C N

Licensed bed days: 23,360 Occupancy: 20,162 Pct. of occupancy: 86.31%

Illinois Public Aid Support Rate $

Genl Services Salary/Wage:	171,568	Col 1, Line 8 ---Audit Adj:	
Genl Admin Salary/Wage	63,074	Col 1, Line 28 ---Audit Adj:	
Total Salary Wage	814,409	Col 1, Line 44 ---Audit Adj:	
Employee Benefits	138,994	Col 8, Line 22 ---Audit Adj:	
Total General Services:	319,843	Col 8, Line 8 ---Audit Adj:	
Total General Admin	380,597	Col 8, Line 28 ---Audit Adj:	

Instructions and Calculation Steps

STEP Adjust Support Service Costs to Include Correct Amounts of Fringe Benefits and Payroll Taxes

Fringe benefits and payroll taxes are reported as a lump sum under General Administration expenses on your cost report (Page 3, Column 10, Line 22). You will need to take this amount out of General Administration expenses and calculate the correct portions of this lump sum to be added to your general services and General Administration expenses. This is done by proration

A. General Services

1 Determine the proportion of general services wages to total wages.

2 Multiply the total lump sum fringe amount by this proportion to get the fringe amount for General Services.

3 Add the proportioned fringe amount to your total general services expenses to get your new total general services cost.

General Services Wages (Column 1, Line 8	$171,568
Divided by Total Wages (Column 1, Line 44	$814,409
General service wages as percent of total wages	21.0666%
Employee Benefits (Column 10, Line 22	$138,994
Allocation of Employee Benefits to General Services Costs	$29,281
Plus Total General Services (Column 10, Line 8	$319,843
New Total General Services Cost	$349,124

B. General Administration

1 Determine the proportion of General Administration wages to total wages.

2 Multiply the total lump sum fringe amount by the proportion to get the fringes amount for General Administration

3 Add the proportioned fringe amount to your total General Administration expenses

4 Subtract the total lump sum fringe amount from your General Administration expenses to get your new total General Administration Cost

General Administration Wages (Column 1, Line 28	$63,074
Divided by Total Wages (Column 1, Line 45	$814,409
General administration wages as a percent of total wages	7.7448%
Employee Benefits (Column 10, Line 22	$138,994
Allocation of Emplayee Benefits to General Admin. Cost	$10,765
Plus Total General Administration (Column 10, Line 2	$380,597
Minus Total Fringe (Column 10, Line 22	$138,994
New Total General Administration Cos	$252,368

STEP Adjust Support Service Costs for Inflation

To calculate the impact of inflation, different inflation fators are used for the General Service and General Administration costs of your cost report. These inflation factors are listed in Table I, Inflation Multipliers. To select the appropriate inflation factors, you need to calculate your base number using the formula outlined below. Once you have calculated your base number, find it in Table I. Select the inflation factors which correspond with your base number and use these in updating your support cost.

A. Base Number Calculation

Convert the beginning and ending dates of your cost reporting period (page 1, Schedule II of your cost report) into numbers and apply the following formula:

Beginning Month + Ending Month	13 divided by 2 =	6.5
Beginning Day + Ending Day	31 divided by 60.8 =	0.509868421
Beginning Year + Ending Year =	205 multiplied by 6 =	1230
Sum of the three lines		1237.009868
Subtract from the sum		907.00
Base Number (expressed as a whole number, fraction dropped)		330

B. Select the Appropriate Inflation Multiplier

Refer to Table I, inflation Multipliers, and find the multipliers which correspond with the base number you have calculated.

General Services Multiplier	1
General Administration Multiplie	1

C. Apply Inflation Multipliers to Update Cos

1 Multiply New Total General Services Cost (from Step I-A) by the appropriate multiplier from Table

New Total General Service Cost (Step I-A)	$349,124	
General Services Multiplier (Step II-B	1	
Updated General Services Cost		$349,124

2 Multiply New Total General Administration Cos (from Step I-B)by the appropriate multiplier from Table

New Total General Service Cost (Step I-B	$252,368	
General Administration Multiplier (Step II-B	1	
Updated General Services Cost		$252,368
3 Total Updated Support Costs (1 + 2		$601,492

STEP I Convert Total Updated Support Costs (C-3) to Per Diem Cos

Use one of the two procedures below to compute per diem costs.

CALCULATED PER DIEM SUPPORT CO $29.08

A. If the occupancy (Cost Report, Page 2, Schedule III-C) is equal to or above 93 percent, divide your total updated support costs (Step II, C, 3, above) by the total patient days (Cost Report, Page 2, Schedule III-B, Column 5, Line 14

Total Support Costs (Step II, C, 3, above	$601,492
Total Patient Days (Cost Report	20,162
Support Costs per Diem	$29.83

OR

B. If the occupancy is below 93 percent, calculate 93 percent of the licensed bed days (Cost Report, Page 2, Schedule III-A Column 4, Line 7). Then subtract the total patient days (Cost Report, Page 2, Schedule III-B, Column 5 Line 14) from the result and calculate one-third of the difference. Then add the one-third difference to the total patient days to obtain your adjusted occupancy. Next divide your total updated Support Costs (Step II, C, 3 above by your adjusted occupancy.

Licensed Bed Days	23,360
Multiplied by	0.93
	21,725
Minus total Patient Day	20,162
	1,563
One-third of difference	521
Plus Total Patient Day	20,162
Adjusted Occupancy	20,683
Total Support Costs (Step II, C, 3, above	$601,492
Divided by Adjusted Occupany	20683
Support Costs Per Diem	$29.08

STEP IV Calculate Support Rate

The maximum allowable support reimbursement rate is the 75th percentile for your region. The 35th and 75th percentile rates by HSA are listed in Table II, support Rate Percentiles by HSA Use one of the three procedures below and refer to Table II to calculate your support rate.

A. If your support costs per diem from STEP II is equal to or greater than the 75th percentile for your HSA, then your support rate is the 75th percentile rate listed in Table I

B. If your support costs per diem from Step III is equal to or greater than the 35th percentile, but less than the 75th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	$32.69
Minus Support Costs Per Dier	$29.08
Difference	$3.61
Multiply the Difference by	0.5
One-Half of the Difference	$1.81
Plus Support Costs Per Dier	$29.08
Support Rate if costs are between 35th and 75th percentile	30.89

C. If your support cost per diem from Step III is below the 35th percentile for your HSA, then your support rate is your support costs per diem plus 50 percent of the difference between your support costs per diem and the 75th percentile rate up to a ceiling. This ceiling is equal to 50 percent of the difference between the 35th and 75th percentiles plus $.05. The ceiling for each HSA is listed in Table II. Use the following procedure to calculate your rate

75 Percentile Rate for your HSA	$32.69
Minus Support Costs Per Dier	$29.08
Difference	$3.61
Multiply the Difference by	0.5
One-Half of the Difference	$1.81
Compare one-half the difference to the profit ceiling for your HSA in Table II and	2.63
Enter the Lower of the Two Amounts	$1.810
Plus Support Costs Per Dier	$29.08
Support Rate if support costs less than 35th percentile	$30.89

D. YOUR FINAL TOTAL SUPPORT RATE from A, B, or C abc **$30.89**

75th Percentile is	$32.69
35th Percentile is	$27.53

Table

Inflation Multipliers

Base Number	General Services Multiplie	General Administration Multiplie
261	1.1187	1.1531
262	1.1182	1.1530
263	1.1178	1.1528
264	1.1071	1.1376
265	1.1067	1.1375
266	1.1062	1.1373
267	1.0975	1.1249
268	1.0971	1.1248
269	1.0966	1.1246
270	1.0887	1.1134
271	1.0882	1.1132
272	1.0877	1.1130
273	1.0815	1.1043
274	1.0811	1.1042
275	1.0806	1.1040
276	1.0730	1.0932
277	1.0725	1.0931
278	1.0720	1.0929
279	1.0666	1.0853
280	1.0661	1.0851
281	1.0657	1.0850
282	1.0588	1.0753
283	1.0583	1.0751
284	1.0579	1.0750
285	1.0535	1.0690
286	1.0531	1.0689
287	1.0527	1.0687
288	1.0413	1.0524
289	1.0409	1.0522
290	1.0404	1.0521
291	1.0321	1.0403
292	1.0317	1.0402
293	1.0313	1.0400
294	1.0254	1.0318
295	1.0250	1.0317
296	1.0246	1.0315
297	1.0228	1.0294
298	1.0224	1.0293
299	1.0219	1.0291
300	1.0166	1.0218
301	1.0162	1.0216
302	1.0158	1.0215
303	1.0076	1.0098
304	1.0072	1.0097
305	1.0067	1.0095
306	1.0000	1.0000

Table I

SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	40.08	32.10	4.040
2	37.33	31.77	2.830
3	34.36	29.73	2.365
4	37.33	31.77	2.830
5	32.69	27.53	2.630
6	43.80	31.76	6.070
7	43.80	31.76	6.070
8	43.80	31.76	6.070
9	39.02	30.77	4.175
10	40.08	32.10	4.040
11	35.80	29.99	2.955

Table II (For ICF/DD 16 Facilities)

SupportRate percentiles by HSA

HSA	75th Percentile	35th Percentile	Below 35th Profit Ceiling
1	34.86	27.19	3.885
2	33.30	25.97	3.715
3	32.74	25.54	3.650
4	33.30	25.97	3.715
5	30.46	23.75	3.405
6	40.44	31.54	4.500
7	40.44	31.54	4.500
8	40.44	31.54	4.500
9	37.60	29.32	4.190
10	34.86	27.19	3.885
11	32.73	25.52	3.655

Capital Rate Data
Change print Orientation!

YOU HAVE CHOSEN THE CAPITAL CALC. THAT IS LINKED TO THE COST REPORT!!!! 11/04/05 12:43:00 PM
COSTS INCLUDED ON PAGES 12 THRU 12D START AT CELL O6

Facility Name: **Mount Vernon Care Center** ID: **0039826**

HSA No.: 5 Own or Rent? (O or R) o Own or Rent Beginning: 10/4/1994

IF RENTED, have facilities been continously rented from an unrelated party since prior to January 1, 1978 (Y or N): N
or since the first day of operation for buildings constructed since January 1, 1978?

Cost Report Pd:		Licensed Beds:	64	Total Patient Days	20,162
Begin	**07/01/02**	Licensed Bed Days:	23,360	% Occupied	86.31%
End	**06/30/03**			Capital Days	21,725

1989 Property Tax COST: ______ (Actual dollar amount 1989 taxes)

1991 Property Tax RATE: ______ (Inflated dollar amount divided by 1991 capital days)

FY 1991 Capital Rate: ______ (From form 787)

CAPITAL CALCULATIONS

	Calculation Column
A. Determine the base year for your building from Work Table A	1994
B. Determine the Building Specific historical cost per bed:	
1. Work Table A, Line 24, Column (B)	1441509
2. Total licensed beds from cost report Page 2, Line 7, column 3	64
3. Line 1 divided by Line 2	$22,524
4. Regional construction inflator from Table 2	1.22
5. Building specific historical Cost ber bed (Line 3 * Line 4, round to even $)	27479
C. Obtain the Uniform Building Value from Table 1	30881
D. The capital rate will be calculated through a blending of the uniform building value from Line C and the building specific historical cost per bed from Line B5	
1. Building specific historical cost from Line B5	27479
2. Uniform building value from Line C	30881
3. Add Lines 1 and 2	58360
4. Divide by 2 to obtain average	29180
5. Enter 120% of line C	37057
6. The blended value is the lesser of Line 4 or Line 5	29180
E. Divide the blended value from step D by 339 days to obtain a per diem blended value investment	86.0767
F. Multiply the per diem blended value from step E by the applicable rate of return to obtain the building rate factor. (The rate of return is 11% for 1979 and later base years and 9.13% for 1978 and older base years.)	9.47
G. Add $2.50 to Line F for equipment, rent, vehicle and working capital.	2.5
H. Add Lines F & G to obtain the preliminary capital rate	11.97
I. Implementation Capital Rate. (This step does not apply if the facility has been constructed or purchased after FY91.)	
1. Enter the FY 91 capital rate	0
2. Subtract the FY 91 property tax rate	0
3. FY 91 rate without tax	0
4. Multiply Line I3 by 115%	x 1.15%
5. Implementation capital rate	0
J. Property Tax Property taxes are taken from the Long Term Care Property Tax Statement which was submitted to the Department of Public Aid during FY93. Reimbursement for real estate taxes is based upon the actual 1991 taxes for which the nursing homes were assessed. The formula used is a follows:	
1. Property Tax Expense (Long Term Care Property Tax Statement, Column D, Total.)	0
2. Divided by: Capital Days (see below)	21,725
3. Equals: Per Diem Cost	$0.00
4. Times: Property Tax Inflator (Table 3)	1.03753
5. Equals: Updated Property Tax Cost	0
Capital Days The capital days are the higher of the actual census (Page 2, Schedule III-B, Column 5, Line 14) or 93% of licensed bed days (page 2, Schedule III-A, Column 4, Line 7 * .93.)	
1. Total Patient Days	20,162
2. Total Licensed Bed Days * .93	21725
3. Capital Days (higher of Line 1 or Line 2)	21,725
K. Total Capital Rate for FY 94	
1. Enter the greater of the simplified system rate from Line H or the implementation capital rate from Line I	11.97
2. Add Property Tax from Line J5	0
3. Total capital rate (add Lines 1 & 2)	11.97

WORK TABLE A

		Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
1	1	94	1229600	115582400	12
2	2	98	5394	528612	12
3	3	0	0	0	12
4	4	0	0	0	12
5	5	0	0	0	12
6	6	95	3187	302765	12
7	7	96	4794	460224	12
8	8	97	1198	116206	12
9	9	96	1230	118080	12
10	10	96	1710	164160	12
11	11	97	1354	131338	12
12	12	97	3329	322913	12
13	13	97	7822	758734	12
14	14	97	2878	279166	12
15	15	97	20386	1977442	12
16	16	97	4544	440768	12
17	17	97	8933	866501	12
18	18	97	1882	182554	12
19	19	97	4153	402841	12
20	20	97	15420	1495740	12
21	21	97	32765	3178205	12
22	22	97	8366	811502	12
23	23	97	780	75660	12
24	24	98	1340	131320	12
25	25	98	27771	2721558	12
26	26	98	154	15092	12
27	27	98	262	25676	12
28	28	98	7964	780472	12
29	29	98	1599	156702	12
30	30	98	578	56644	12
31	31	99	1699	168201	12
32	32	99	1220	120780	12
33	33	0	0	0	12
34	34	99	6059	599841	12A
35	35	99	1245	123255	12A
36	36	99	1990	197010	12A
37	37	99	3343	330957	12A
38	38	99	3477	344223	12A
39	39	99	942	93258	12A
40	40	99	3212	317988	12A
41	41	99	671	66429	12A
42	42	100	984	98400	12A
43	43	100	1500	150000	12A
44	44	101	1803	182103	12A
45	45	100	13971	1397100	12A
46	46	0	0	0	12A
47	47	0	0	0	12A
48	48	0	0	0	12A
49	49	0	0	0	12A
50	50	0	0	0	12A
51	51	0	0	0	12A
52	52	0	0	0	12A
53	53	0	0	0	12A
54	54	0	0	0	12A
55	55	0	0	0	12A
56	56	0	0	0	12A
57	57	0	0	0	12A
58	58	0	0	0	12A
59	59	0	0	0	12A
60	60	0	0	0	12A
61	61	0	0	0	12A
62	62	0	0	0	12A
63	63	0	0	0	12A
64	64	0	0	0	12A
65	65	0	0	0	12A
66	66	0	0	0	12A
67	67	0	0	0	12B
68	68	0	0	0	12B
69	69	0	0	0	12B
70	70	0	0	0	12B
71	71	0	0	0	12B
72	72	0	0	0	12B
73	73	0	0	0	12B
74	74	0	0	0	12B
75	75	0	0	0	12B
76	76	0	0	0	12B
77	77	0	0	0	12B
78	78	0	0	0	12B
79	79	0	0	0	12B
80	80	0	0	0	12B
81	81	0	0	0	12B
82	82	0	0	0	12B
83	83	0	0	0	12B
84	84	0	0	0	12B
85	85	0	0	0	12B
86	86	0	0	0	12B
87	87	0	0	0	12B
88	88	0	0	0	12B
89	89	0	0	0	12B
90	90	0	0	0	12B
91	91	0	0	0	12B
92	92	0	0	0	12B
93	93	0	0	0	12B
94	94	0	0	0	12B
95	95	0	0	0	12B
96	96	0	0	0	12B

	Year Acquired (A) Last 2 digits only	Cost (B)	Columns (A) * (B) (C)	Linked Page
97	0	0	0	12B
98	0	0	0	12B
99	0	0	0	12C
100	0	0	0	12C
101	0	0	0	12C
102	0	0	0	12C
103	0	0	0	12C
104	0	0	0	12C
105	0	0	0	12C
106	0	0	0	12C
107	0	0	0	12C
108	0	0	0	12C
109	0	0	0	12C
110	0	0	0	12C
111	0	0	0	12C
112	0	0	0	12C
113	0	0	0	12C
114	0	0	0	12C
115	0	0	0	12C
116	0	0	0	12C
117	0	0	0	12C
118	0	0	0	12C
119	0	0	0	12C
120	0	0	0	12C
121	0	0	0	12C
122	0	0	0	12C
123	0	0	0	12C
124	0	0	0	12C
125	0	0	0	12C
126	0	0	0	12C
127	0	0	0	12C
128	0	0	0	12C
129	0	0	0	12C
130	0	0	0	12C
131	0	0	0	12D
132	0	0	0	12D
133	0	0	0	12D
134	0	0	0	12D
135	0	0	0	12D
136	0	0	0	12D
137	0	0	0	12D
138	0	0	0	12D
139	0	0	0	12D
140	0	0	0	12D
141	0	0	0	12D
142	0	0	0	12D
143	0	0	0	12D
144	0	0	0	12D
145	0	0	0	12D
146	0	0	0	12D
147	0	0	0	12D
148	0	0	0	12D
149	0	0	0	12D
150	0	0	0	12D
151	0	0	0	12D
152	0	0	0	12D
153	0	0	0	12D
154	0	0	0	12D
155	0	0	0	12D
156	0	0	0	12D
157	0	0	0	12D
158	0	0	0	12D
159	0	0	0	12D
160	0	0	0	12D
161	0	0	0	12D
162	0	0	0	12D

Base year:
Total of Column C/Total of Column B = Base Year

136272820 1441509 94.53483815

Base Year = 1994

TABLE 1 2

Table 1 Uniform building Value

Uniform Building Value

Base year	6, 7, 8 & 9	1, 2, 3, 4, 5, 10 & 11
1970	4114	3766
1971	5348	4896
1972	6583	6026
1973	7817	7155
1974	9051	8285
1975	10285	9415
1976	11519	10545
1977	12754	11675
1978	13988	12804
1979	15222	13934
1980	16456	15064
1981	17691	16194
1982	18925	17324
1983	20159	18453
1984	21393	19583
1985	22628	20713
1986	23862	21843
1987	25096	22973
1988	26330	24102
1989	27564	25232
1990	28799	26362
1991	30033	27492
1992	31267	28622
1993	32501	29751
1994	33736	30881
1995	34970	32011
1996	36204	33141
1997	37438	34271
1998	38673	35400
1999	39907	36530
2000	41141	37660

Use the 1970 values for all years prior to 1970

TABLE 2 2

Construction Inflators by year and HSA
(Note: Use the 1960 Inflators for all years prior to 1960)
(For the FY94 Nursing Facility Rate Calculation Packet)

Year	1, 2 & 10	3, 4 & 5	11	6, 7, 8 & 9
1960	6.26	6.08	6.29	6.54
1961	5.67	5.52	5.66	5.87
1962	5.67	5.52	5.66	5.87
1963	5.67	5.52	5.66	5.87
1964	5.67	5.52	5.66	5.87
1965	5.67	5.52	5.66	5.87
1966	5.36	5.23	5.35	5.55
1967	5.1	4.97	5.08	5.28
1968	4.85	4.71	4.83	5.03
1969	4.61	4.48	4.59	4.79
1970	4.38	4.25	4.36	4.56
1971	4.01	3.89	3.98	4.15
1972	3.64	3.53	3.63	3.78
1973	3.36	3.26	3.36	3.48
1974	3.08	3	3.09	3.19
1975	2.83	2.77	2.8	2.91
1976	2.73	2.65	2.74	2.82
1977	2.57	2.48	2.55	2.68
1978	2.37	2.29	2.38	2.49
1979	2.18	2.12	2.21	2.32
1980	1.96	1.92	2.02	2.08
1981	1.8	1.76	1.86	1.91
1982	1.67	1.63	1.72	1.76
1983	1.54	1.5	1.57	1.65
1984	1.51	1.47	1.55	1.62
1985	1.48	1.45	1.5	1.59
1986	1.46	1.42	1.46	1.55
1987	1.44	1.4	1.43	1.52
1988	1.4	1.36	1.39	1.46
1989	1.35	1.33	1.35	1.41
1990	1.32	1.31	1.33	1.34
1991	1.29	1.29	1.3	1.31
1992	1.26	1.26	1.27	1.26
1993	1.25	1.24	1.25	1.23
1994	1.22	1.22	1.22	1.19
1995	1.2	1.2	1.19	1.17
1996	1.12	1.11	1.13	1.12
1997	1.1	1.09	1.1	1.1
1998	1.08	1.07	1.07	1.07
1999	1.04	1.04	1.04	1.04
2000	1.02	1.02	1.02	1.03
2001	1.00	1.00	1.00	1.00
2002	1.00	1.00	1.00	1.00

TABLE 3

Property Tax Inflator

HSA	Rate
1	1.05723
2	1.0395
3	1.0333
4	1.03302
5	1.03753
6	1.02368
7	1.02054
8	1.02613
9	1.01315
10	1.0815
11	1.03527

TABLE 4

Table 2 column

HSA	Column
1	1
2	1
3	2
4	2
5	2
6	4
7	4
8	4
9	4
10	1
11	3

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	78,997	8,529	4,259	91,785	0	91,785	0	91,785
2. Food Purchase	0	76,411	0	76,411	0	76,411	-10,125	66,286
3. Housekeeping	51,893	5,987	0	57,880	0	57,880	0	57,880
4. Laundry	30,147	7,301	0	37,448	0	37,448	0	37,448
5. Heat and Other Utilities	0	0	37,889	37,889	0	37,889	0	37,889
6. Maintenance	10,531	0	18,024	28,555	0	28,555	0	28,555
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	171,568	98,228	60,172	329,968	0	329,968	-10,125	319,843
9. Medical Director	0	0	6,000	6,000	0	6,000	0	6,000
10. Nursing & Medical Records	539,853	21,809	622	562,284	0	562,284	30	562,314
10a. Therapy	0	0	112	112	0	112	0	112
11. Activities	15,869	1,972	1,207	19,048	0	19,048	0	19,048
12. Social Services	17,048	0	698	17,746	0	17,746	0	17,746
13. Nurse Aide Training	6,997	0	1,448	8,445	0	8,445	0	8,445
14. Program Transportation	0	0	264	264	0	264	0	264
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	579,767	23,781	10,351	613,899	0	613,899	30	613,929
17. Administrative	44,019	0	99,000	143,019	0	143,019	0	143,019
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	720	720	0	720	18,507	19,227
20. Fees, Subscriptions & Promotion	0	0	2,555	2,555	0	2,555	38	2,593
21. Clerical & General Office	19,055	3,198	13,854	36,107	0	36,107	2,283	38,390
22. Employee Benefits & Payroll	0	0	98,384	98,384	0	98,384	40,610	138,994
23. Inservice Training & Education	0	0	50	50	0	50	0	50
24. Travel and Seminar	0	0	779	779	0	779	254	1,033
25. Other Admin. Staff Trans	0	0	95	95	0	95	0	95
26. Insurance-Prop.Liab.Malpractice	0	0	-63	-63	0	-63	37,259	37,196
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	63,074	3,198	215,374	281,646	0	281,646	98,951	380,597
29. Total General Administrative	814,409	125,207	285,897	1,225,513	0	1,225,513	88,856	1,314,369
30. Depreciation	0	0	6,275	6,275	0	6,275	62,795	69,070
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	1,523	1,523	0	1,523	171,122	172,645
33. Real Estate	0	0	0	0	0	0	0	0
34. Rent - Facility & Grounds	0	0	256,545	256,545	0	256,545	-256,545	0
35. Rent - Equipment & Vehicles	0	0	344	344	0	344	0	344
36. Other (specify):*	0	0	0	0	0	0	2,439	2,439
37. Total Ownership	0	0	264,687	264,687	0	264,687	-20,189	244,498
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	0	0	0	0	0	0	0
40. Barber and Beauty Shop	0	0	0	0	0	0	0	0
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42. Provider Participation	0	0	35,040	35,040	0	35,040	0	35,040
43. Other (specify):*	0	0	7,687	7,687	0	7,687	-7,687	0
44. Total Special Cost Ce	0	0	42,727	42,727	0	42,727	-7,687	35,040
45. Grand Total	814,409	125,207	593,311	1,532,927	0	1,532,927	60,980	1,593,907

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	38,063	38,063
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	195,325	195,325
4. Supply Inventory	0	0
5. Short-Term Investments	0	0
6. Prepaid Insurance	12,654	12,654
7. Other Prepaid Expenses	4,653	4,653
8. Accounts Receivable-Owner/Related Party	483,710	483,710
9. Other (specify):	4,136	4,136
10. Total current assets	738,541	738,541
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	0	0
13. Land	0	60,000
14. Buildings, at Historical Cost	0	1,234,994
15. Leasehold Improvements, Historical Cost	6,276	206,515
16. Equipment, at Historical Cost	39,557	250,387
17. Accumulated Depreciation (book methods)	-23,246	-525,940
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	1,500	1,500
24. Total Long-Term Assets	24,087	1,227,456
25. Total Assets	762,628	1,965,997
CURRENT LIABILITIES		
26. Accounts Payable	53,867	53,867
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	6,220	6,220
30. Accrued Salaries Payable	43,630	43,630
31. Accrued Taxes Payable	0	0
32. Accrued Real Estate Taxes	0	0
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	0	0
36. Other Current Liabilities (specify):	612,328	67,170
37. Other Current Liabilities (specify):	0	0
38. Total Current Liabilities	716,045	170,887
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	1,954,072
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	1,954,072
46.Total Liabilities	716,045	2,124,959
47.Total Equity	46,583	-158,962
48.Total Liabilities and Equity	762,628	1,965,997

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	1,551,268
2. Discounts and Allowances for all Levels	0
Subtotal - Inpatient Care	1,551,268
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	1,418
7. Oxygen	0
Subtotal - Anciliary Revenue	1,418
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	4,787
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	650
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	0
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	4,124
22. Laundry	0
Subtotal - Other Operating Revenue	9,561
24. Contributions	0
25. Interest and Other Investments Income	381
Subtotal - Non-Operating Revenue	381
27. Other Revenue (specify):	0
28. Other Revenue (specify):	44,072
Subtotal - Other Revenue	44,072
30. Total Revenue	1,606,700
31. General Services	329,968
32. Health Care	613,899
33. General Administration	281,646
34. Ownership	264,687
35. Special Cost Centers	7,687
35. Provider Participation Fee	35,040
37. Other	0
40. Total Expenses	1,532,927
41. Income Before Income Taxes	73,773
42. Income Taxes	0
43. Net Income or Loss for the Year	73,773
42. Income Taxes	0
43. Net Income or Loss for the Year	60,899

Page	
1	
2	
3	
4	
5	
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23	Provider Participation fee is linked from page 4